LIBERALS PLAYING POLITICS WITH MEDICARE REFORM 6 | PLAY OR PAY REPEAL WILL BE ON CAL. BALLOT 8 | VERMONT MELTDOWN p9

HEALTH CARE NEWS

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Medicare HMO Premiums Plummet

by Conrad F. Meier

Millions of seniors enrolled in private-sector Medicare HMOs are getting a big surprise: lower health insurance premiums and increased benefits. HMOs for the elderly are offering substantial rate cuts and benefit increases in response to a $500 million boost from the federal government this year.

The new Medicare law signed by President George W. Bush in December 2003 not only created a prescription drug benefit but also gave private-sector health

PLUMMET continued on page 17

Minnesotans Polled on Government-Run Health Care

by Twila Brase

On January 12, the Minnesota Citizens Forum on Health Care Costs released a draft report of findings it reached after a telephone survey of Minnesota residents. As chair of the 18-member panel appointed by Governor Tim Pawlenty (R), former U.S. Senator David Durenberger (R) called universal health care a "Minnesota value."

Minnesota Public Radio quoted panelist Dr. Glen Nelson, former surgeon and a member of the Jackson Hole Group: "There

MINNESOTANS continued on page 16

Colorado Wrestles with Evidence-Based Medicine

by Linda Gorman

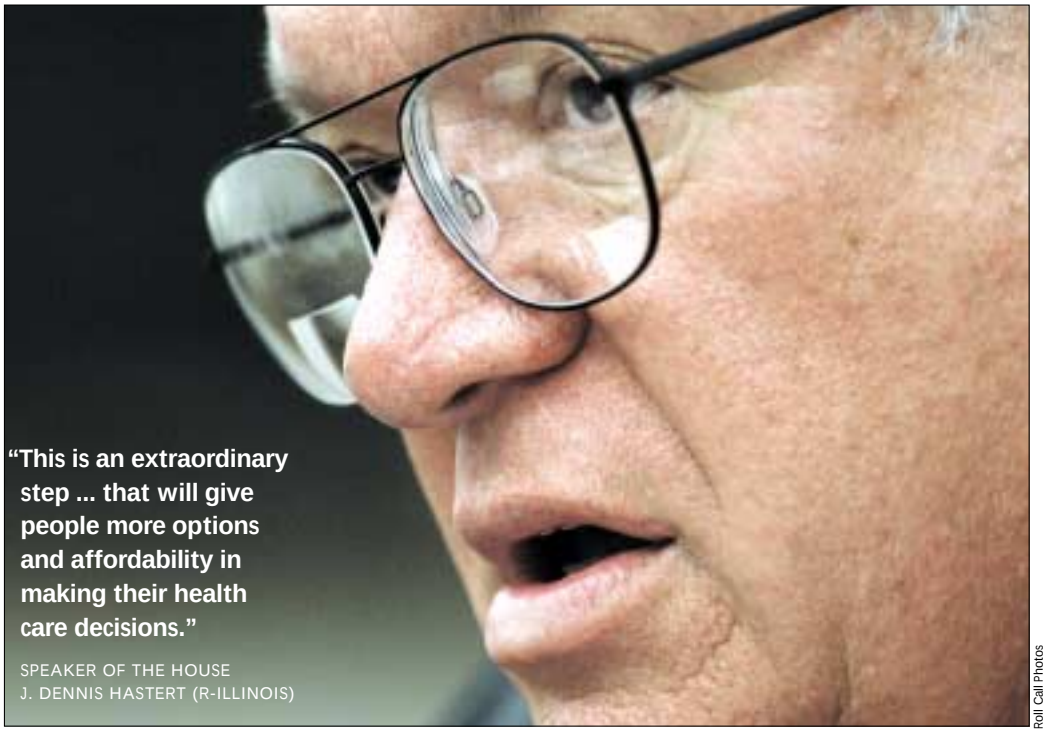
Statutory language requiring the use of "evidence-based medicine" (EBM) in programs from Medicaid to workers' compensation will reportedly be presented to the Colorado General Assembly in 2004.

EBM will be defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual injured persons entitled to benefits." The individual clinical expertise of a "health care provider" will

COLORADO continued on page 7

FIRST HSA SOLD IN ILLINOIS

A Critical Moment for Health Care in America


"This is an extraordinary step ... that will give people more options and affordability in making their health care decisions."
SPEAKER OF THE HOUSE
J. DENNIS HASTERT (R-ILLINOIS)

Roll Call Photos

by Steve Stanek

Pamela Wimbish of Aurora, Illinois has the distinction of being the nation's first person to hold a Health Savings Account (HSA) insurance policy.

Her policy took effect January 1, the first day HSAs became available. The policy was issued by Milwaukee-based Fortis Health through insurance agent Scott Leander of Wheaton, Illinois.

"This was a no-brainer," Wimbish said of her insurance policy purchase. "One hundred percent of the deductible can go to the HSA for any medical expense, even ones that may not be covered by the policy. It's funded with pre-tax dol-

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INSIDE HCN

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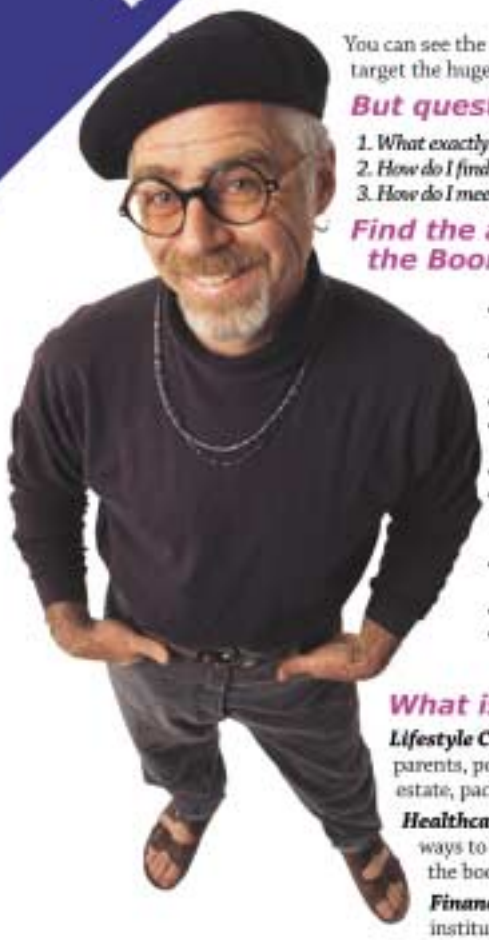
It's time to retire your old ideas about "Aging Boomers"!



You can see the marketers' eyes light up as they think about the riches that await them as they target the huge Baby Boomer generation ... an aggregate income estimated at $4.1 trillion!

But questions remain:

1. *What exactly are the Boomers looking for?*
2. *How do I find them?*
3. *How do I meet their needs?*

Find the answers from the leaders who will speak at the Boomers Business Conference & Expo:

- ***Richard Adler, President, People & Technology***
- ***Robert Blancato, President, Matz, Blancato & Associates Inc.***
- ***Liz Boehm, Analyst, Forrester Research***
- ***Berry Brunk, CEO, Laconner Technologies***
- ***Joe Coughlin, Director, MIT Age Lab***
- ***Neal Cutler, Professor, School of Human Service Professions, Widener University***
- ***Christine Fahland, Senior Financial Planner, T. Rowe Price***
- ***Bruce Goodman, VP/CIO, Humana***
- ***Bradford Holmes, Healthcare Research Director, Forrester Research***
- ***Wendy Borow-Johnson, President & Founder, Healthy Living Channel***
- ***Susannah Kirsch, Research Director, Institute of The Future***
- ***John Martin, Chairman/CEO, SIR Associates***
- ***John Migliaccio, PhD, President, American Institute of Financial Gerontology***
- ***Russ Ricci, Chairman, US Wellness***
- ***Dallas Salisbury, Executive Director, Employee Benefit Research Institute***
- ***Tori Tomlinson, Founder/CEO, US Wellness***
- ***Jack Wolf, VP, Eastern Group Managed Care - HCA***

What is covered at the Boomers Business Expo?

Lifestyle Considerations for Boomers - how boomers are dealing with their elderly parents, post-college children, their jobs and plans for retirement. Learn how travel, real estate, package goods and other companies are rethinking their strategies.

Healthcare Considerations for Boomers - Leaders in the industry will discuss innovative ways to assess wellness, health, insurance, and other key healthcare related concerns of the boomers as they age.

Financial and Retirement Funding Considerations for Boomers - Meet the financial institutions that are leading the curve in marketing to the aging Boomers, including insurance agencies, financial planners, stockbrokers and other stakeholders.

Technologies for Boomers - Boomers know a whole lot about technology ... and expect it in all parts of their lives. Learn what this means to your products and services.

Why should you sponsor or exhibit?

- ***To help other companies market to Boomers***
- ***To partner with other companies to market Boomer products***

Who Should Attend?

CEOs, COOs, CFOs, CMOs, Pharmaceutical Executives, Insurance Agents, Financial Planners, Retirement/Benefit Directors, Consulting Firms, Marketing Executives, Product Managers, Brand Managers, Advertising Executives, e-Commerce marketers, Business Development Executives, Health Care Executives, Media Planners and Buyers

Anyone who has the desire to understand how to market to Boomers and how to create relationships of value that can be leveraged to reach new Boomer segments.

A Strategic Combination: Co-located with CDHCC!

The Boomers Business Conference & Expo will be co-located with the spring Consumer Directed Health Care Conference & Expo (CDHCC) and will share selected keynote addresses, the "Technologies Transforming Healthcare and Retirement" track and a common exhibit hall. This strategy recognizes the importance of the evolving consumer directed health care industry on the Boomers generation. For more information, visit www.cdhcc.com, or call 804-266-7422.

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For Exhibit & Sponsorship information, contact Katie Doyle, katie@boomersbusiness.com; 804-266-7422 ext.7421.

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$30 Million Awarded to High-Risk Pools

by **Tom Bruderle**

In late December, the Department of Health and Human Services awarded $30 million in grants to 16 states to help meet the health insurance expenses of residents with preexisting conditions who are unable to obtain private health coverage and are enrolled in high-risk pools.

To be eligible for a grant under the Trade Adjustment Assistance Reform Act of 2002, a state must have a "qualified" high-risk pool that caps premiums at no more than 150 percent of the standard premium rate in that state. It must also agree to meet up to one-half the cost of running the pool. Grants are distributed based on the state's number of uninsured residents.

Grants were presented to Alaska, Arkansas, Colorado, Connecticut, Illinois, Indiana, Iowa, Kansas, Kentucky, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, and Oklahoma.

Maryland and South Dakota are taking steps to create high-risk pools.

State Versus Federal Regulation

Since early January, the leaders of some of the nation's largest insurance companies have been lobbying members of Congress in support of a single federal regulator to assume responsibility for overseeing the industry. The idea is especially appealing to insurance companies that do business across the country and thus must comply with a variety of state mandates and requirements.

Under proposals circulating on Capitol Hill, multi-state companies would be chartered by the federal government rather than individual states. The companies could revert to state oversight if they found federal rules too restrictive. In exchange, those opting for federal regulation would surrender an antitrust law exemption permitting them to share claims information.

Smaller firms, or those doing business in a single state, would not be required to submit to a federal charter.

Some insurers argue there are inherent inefficiencies in state regulatory systems that place them and their consumers at a disadvantage. Federal regulation, they say, would allow insurers to more quickly and effectively respond to increasing competition from the banking and mutual fund communities, each of which has federal oversight.

Congress and federal agencies would not take action affecting the banking and mutual fund industries without considering the views of the Comptroller of the Currency, the Federal Reserve, or the Securities and Exchange Commission. The insurance industry has no similar entity to explain its position on policies under consideration. "We have no one sitting at the table," one executive said.

"[T]he leaders of some of the nation's largest insurance companies have been lobbying members of Congress in support of a single federal regulator to assume responsibility for overseeing the industry."

The National Association of Insurance Commissioners (NAIC) opposes increasing the federal government's regulatory role. Mike Pickens, insurance commissioner for the state of Arkansas and NAIC president, told a congressional hearing in November that any role for Washington would "add additional layers of harmful uncertainty, confusion, and cost for policyholders and claimants."

Iowa Insurance Commissioner Therese Vaughan said, "There is no reason to think that a one-size-fits-all approach from Washington is going to be appropriate."

A report released in September 2003 by the General Accounting Office, the investigating arm of Congress, concluded states were more concerned with the financial stability of companies doing business within their borders than they were with whether customers were being treated fairly.

Rep. Richard Baker (R-Louisiana), the third ranking Republican on the House Financial Services Committee and chairman of its subcommittee on capital markets, insurance, and government-sponsored enterprises, told last fall's congressional hearing that the states were not doing enough to improve regulation of the insurance industry.

"Perhaps we need to have a clock that says when time is up, Congress will have no choice but to step in and do something," Baker said. "Some say a solution like an optional federal charter is unacceptable. I say that no reform is likewise unacceptable."

Tom Bruderle is vice president of congressional affairs for the National Association of Health Underwriters (NAHU). His email address is **tbruderle@nahu.org**.

Correction: The open letter titled "Economists Warn of Dangers of Drug Importation, Price Controls," published in the February 2004 issue, was written by Kevin Hasset and others. Dr. Milton Friedman signed the letter but was not its author. *Health Care News* regrets the error.

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CDHCC SPRING 2004

www.cdhcc.com

March 29-31, 2004
Las Vegas Hilton, Las Vegas, NV

In 2003, more than 1000 industry leaders gathered for the Consumer Directed Health Care Conference and Expo. Again in 2004, CDHCC will bring many of the countries top employer, health plan and provider community executives in an educationally rich and quality networking environment.

CDHCC is designed for employers, health plans, providers and policy makers. It focuses on providing a marketplace to express ideas about the market numbers, market trends and issues. Attendees are exposed to a wide assortment of topics from specific case studies, exploring the intricacies of health care, from national health care policies and the influx of the elderly, to the benefits of using decision support tools.

CDHCC will be co-located with the first Boomers Business Conference & Expo, a show focusing on the extraordinary purchasing power of a huge market segment. Shared keynote sessions and a shared exhibit hall will enhance the CDHCC experience for attendees.

Program Tracks include:

Employer Community - Addressing the emerging developments and presenting case studies for employers wrestling with rising health care costs, productivity losses from health care related issues and the current standing of employees participating in consumer driven health models.

Provider/Pharma Community - Highlighting the key issues, from rising health costs and the quality of delivery to the impact of a more informed consumer/patient.

Health Plan/Broker/Agent Community - Featuring the latest health plan designs for health care consumers and employers.

Technologies Transforming Healthcare and Retirement - Focuses on the latest technologies impacting consumer driven health care and the emerging seniors market (boomers).

Keynote speakers include:

- Tom Scully, Former Administrator, Center for Medicare/Medicaid Services
- Jeff Lemieux, Senior Economist, Progressive Policy Institute/Executive Director, Centrists.Org
- Doug Kronenberg, Chief Strategy Officer, Lumenos
- Neil Trautwein, Director of Employment Policy, National Association of Manufacturers
- Grace-Marie Turner, Founder, President & Trustee, Galen Institute, Inc.
- Greg Scandlen, Director of Center for Consumer Driven Health Care, Galen Institute, Inc.
- Bruce Goodman, CIO, Humana, Inc.
- Jack Wolf, VP, Hospital Corp. America (HCA)
- Bradford Holmes, Healthcare Research Director, Forrester Research, Inc
- Joe Coughlin PhD, Founding Director, MIT AgeLabs
- Wendy Borow-Johnson, SVP, Turner Media Group/President, Healthy Living Channel

Keynote topics include:

- **Implications of HSA's on Consumer Directed Healthcare**
- **Implications of Recent Healthcare Reform for Consumers and Boomers**
- **Reform or Transform: Where To Next/Where Will We End Up**
- **Finding Common Ground (or Not) in CDH**
- **Where Is Consumer Directed Healthcare Headed/Considerations for the Boomers?**
- **Technology's Impact on the Consumers/Boomers Marketplace**
- **Implications of the Aging Workforce**

Consumer Directed Health Care Conference & Expo

Who Should Attend?

Employer Community:
- **CEOs, COOs, CFOs**
- **HR Benefit Consultants/Managers/Directors**
- **HR Directors/Managers**

Health Plan Community:
- **Health Plan Executives**
- **Medical Directors**
- **Medical and Disease Management Professionals**
- **eHealth/IT Directors**
- **Plan Design Managers**
- **Brokers/Agents**
- **Business Development Managers**

Provider and Pharmaceutical Community:
- **Medical Directors**
- **Physicians**
- **Hospital and Health System Executives**
- **Managed Care Contracting Executives**
- **eHealth/IT Directors**
- **Medical Group Directors**
- **Practice, Office and Physician Relations Managers**
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Health Care 2004

The Candidates Stake Out Positions

by Conrad F. Meier

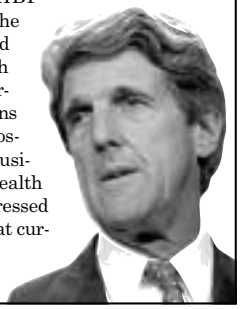
MANAGING EDITOR'S NOTE: Health care rates high on the list of issues taxpayers and voters want Presidential candidates to address during this year's campaign. In the April 2003 issue of *Health Care News* we offered an analysis of where the Democratic candidates stood on health care issues. Since then, Carol Moseley Braun, Wesley Clark, Dick Gephardt, and Joseph Lieberman have dropped out, and some candidates have more clearly defined their positions. Our update now includes the front-running Republican candidate.

PRESIDENT GEORGE W. BUSH

IN DECEMBER 2003, THE PRESIDENT SIGNED landmark legislation reforming Medicare, creating a prescription drug program and tax-favored health savings accounts and increasing reimbursement rates to private HMOs enrolling Medicare beneficiaries. His current plan calls for additional tax breaks designed to help the insured, uninsured, and under-insured pay for health insurance premiums. Bush also was successful in directing $50 million to the states to help finance high-risk health insurance pools.

JOHN KERRY

KERRY SUGGESTS EXPANDING THE FEHBP to private citizens and extending eligibility for the SCHIP program to age 24. The unemployed would get a 75 percent tax credit to help pay for health insurance. Kerry endorses an undefined health insurance tax credit for small business and allowing persons as young as 55 to enroll in Medicare. He also proposes creating a loosely defined "rebate pool" to help businesses pay for the cost of providing catastrophic health care coverage for their employees. He has not addressed how the rebate pool would work in the 30 states that currently have high-risk pools for the medically uninsured and uninsurable.



HOWARD DEAN

EARLY IN HIS CAMPAIGN FOR THE DEMOCRATIC PARTY'S nomination, Dean proposed a national health care system, funded in part by a repeal of all the tax cuts passed by the Bush administration. As the former governor of Vermont, Dean points to his state as a model for his reform ideas. (This issue of *Health Care News* offers an in-depth look at the consequences of the reforms adopted in Vermont under Dean's watch.)

As he did in Vermont, Dean would expand Medicaid to reach more low- and middle-income families and the working poor. He would offer tax credits to help middle-income workers buy insurance, similar to that offered through the Federal Employees Health Benefits Program (FEHBP), and he would pay 70 percent of insurance costs for people temporarily between jobs. He also would mandate employers extend COBRA benefits for an additional two months.

DENNIS KUCINICH

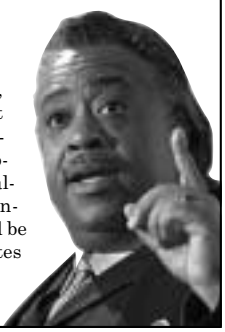
KUCINICH HAS SAID LITTLE ABOUT HIS health care reform plans, except that he would repeal all tax cuts for "the wealthiest Americans" and create a single-payer health care system of national health insurance.

JOHN EDWARDS

EDWARDS WANTS TO PROVIDE HEALTH insurance for every child in America through health insurance and tax breaks for families earning less than $60,000 a year. Children from infancy through age 21 would be covered by a mandate requiring parents to purchase private health insurance on their children's behalf or enroll them in a government program. Edwards also would expand eligibility for Medicare to age 55. He, too, supports a 70 percent tax credit to help people pay for insurance while between jobs.

AL SHARPTON

UNIQUE AMONG THE CANDIDATES, Sharpton is calling for a Constitutional amendment guaranteeing the right to health care of equal quality for everyone. He says he would establish a global budget of $400 billion a year to spend on a socialized, single-payer health care plan offering standardized benefits to all Americans. Each state would be allocated a share of the global budget, and the states would handle all administrative tasks, including claims processing and premium collection.



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Liberals' Medicare Reform Proposal Is Just Plain Politics

by **Joseph L. Bast**

On February 5, two U.S. Senators, Ron Wyden (D-Oregon) and Olympia Snowe (R-Maine), introduced legislation allowing the federal government to directly negotiate drug prices with private drug companies. The legislation, called the "Medicare Enhancements for Needed Drugs Act," also takes steps to legalize the importation of drugs from Canada and penalize drug companies that limit their exports to Canada.

This bill is just plain politics. The ink is barely dry on the Medicare Prescription Drug, Improvement, and Modernization Act, which President Bush signed on December 8, and already liberal Democrats and liberal Republicans are trying to score election-year points by promising voters something for nothing. In this case, they are promising cheaper drugs for seniors that are just as safe and effective as the drugs they are buying today. It's a promise they can't keep.

The clause in the Medicare reform act at issue was put there to protect, not limit, negotiations for lower drug prices for seniors. Here's the actual language of the clause:

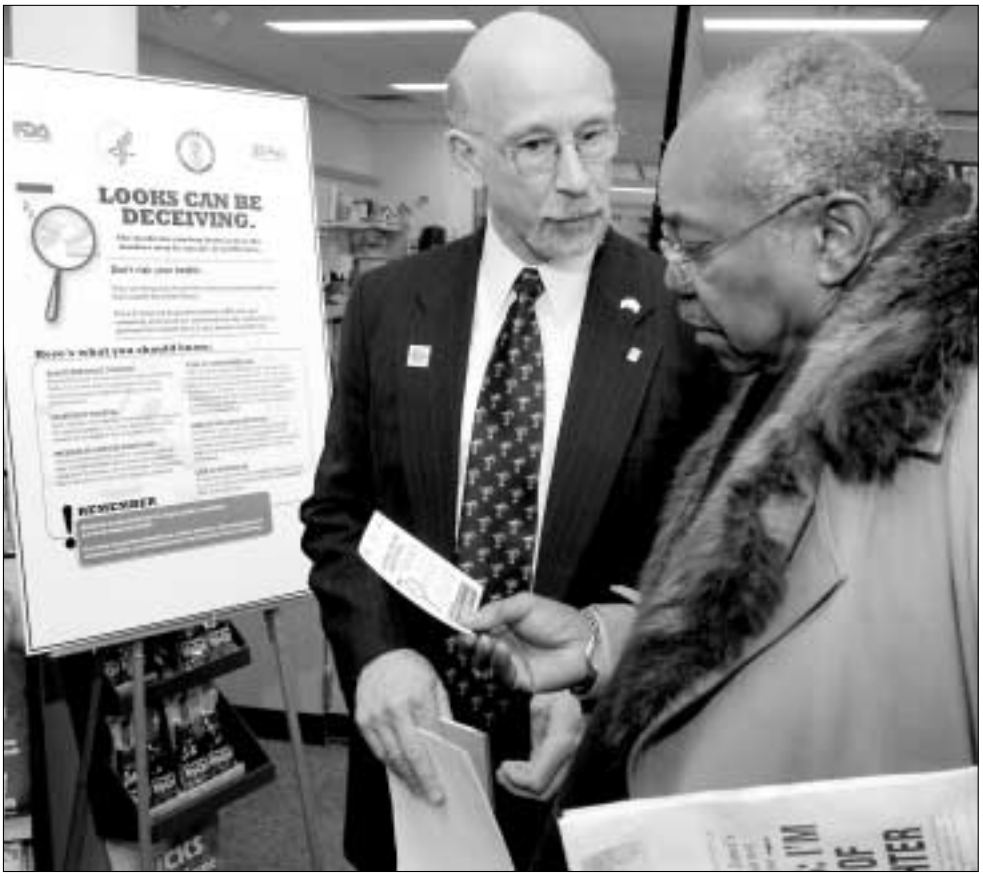
"1860D - 11(i) NONINTERFERENCE In order to promote competition under this part and in carrying out this part, the Secretary (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs."

Under the law, competitive bidding occurs between drug companies and private benefit management companies competing to provide the most popular plans. This clause simply keeps the government from bullying into the process by imposing national price controls. This clause is a good thing—a reminder that this program is to be privately delivered, not run by government bureaucrats.

Private negotiations will achieve significant savings for seniors. We have evidence of this from existing private drug insurance programs. AARP's 35 million members saved $402 million in 2003; Reader's Digest also offers coverage that saves its members hundreds of millions of dollars. Major employers and HMOs negotiate directly with drug companies for discounts. We don't need government to negotiate prices to take advantage of large numbers of buyers.

Government bureaucrats shouldn't be trusted to do this job. Do we really think the same folks who gave us $500 toilet seats and $1,200 hammers would do a better job negotiating for lower prices than private drug benefit management firms that specialize in doing this? In the private sector, drug benefit management companies survive only if they can negotiate better prices than their competitors. In government, there is no competition, no benchmarking, and no penalties for wasting taxpayer money.

Governments, in fact, don't "negotiate" prices, they set a price and punish firms that fail to sell at that price. For example, in Canada and much of Europe, refusal to sell at the government-determined price can result in domestic firms being licensed to produce patented drugs. Here in the U.S., threats were made to suspend the patent rights of manufacturers of Cipro, the smallpox vaccine, if they did not lower their prices. In Illinois and Minnesota, state attorneys general are threatening legal action against drug companies that limit their exports to Canada to discourage reimportation. *This isn't negotiation. It's price controls.*



PR Newswire

Illinois Pharmacists Association President Scott Drabant discusses the dangers of purchasing illegally imported medicines with customer Lee H. Walker at a pharmacy in Chicago on February 4.

"Negotiations" by state governments with drug companies for rebates and supplemental rebates under Medicaid have led to restrictive formularies (limiting access to the newest drugs), cost-shifting (resulting in higher prices for the uninsured and privately insured), and *de facto* price controls. Price controls on oil and natural gas led to the "energy crisis" of the Carter years, which ended only when President Reagan ended price controls. Studies show drug price controls in Europe cost citizens more—in lost wages, profits, and poor health—than they save in cheaper drugs.

"The ink is barely dry on the Medicare Prescription Drug, Improvement, and Modernization Act, ... and already liberal Democrats and liberal Republicans are trying to score election-year points by promising voters something for nothing."

If given the power, politicians *always* set prices too low. The reason is the benefits of lower prices are immediate and visible, while the costs are largely invisible and longer-term ... after voters have forgotten or the politician has left office. The result is less investment, innovation, competition, and consumer choice in the price-controlled industry.

Price controls also lead to less effective and less safe drugs. Drug companies that invest the least in research and quality control are most able to afford to capitulate to government price controls, rewarding those companies that contribute the least to new drug discovery and existing drug safety. Drugs that lose in a fair competition with other drugs are also favored, since restrictive drug formularies force doctors to prescribe them even though doctors know another drug not on the formulary would be superior. In both cases, the lives of patients are put at risk.

Congress's own health care plan doesn't allow government to negotiate directly with drug companies. The Federal Employees Health Benefits Program (FEHBP), often cited as a model for national health insurance reform, relies on private health plans to negotiate drug price discounts on behalf of federal employees. This is not an accident: The program allows a wide variety of plans to meet the needs and situations of its members. A single restrictive drug formulary would not be best for every federal employee ... nor would it be best for America's seniors.

So why are liberal Democrats and Republicans demanding government price negotiation now? The timing is very suspicious. Wyden and Snow both have supported bills in the past that prohibit the federal government from negotiating directly with drug companies: S.1185 (2001), S.2719 (2002, Snowe only), and S.1 (2003). President Clinton's Medicare modernization proposal specifically prohibited direct government negotiation. Similar noninterference language has appeared in most of the Medicare reform bills introduced by Democratic senators and representatives over the years.

A few weeks ago, Democratic Presidential candidate Howard Dean said, "You know why 50 percent of the people in this country don't vote? It's because they hear politicians [making unrealistic promises] every single time before an election, and then they forget about it when they get to Washington." [*Washington Times*, January 27] Dean is absolutely right. Voters should ignore the false promise of cheaper and safer drugs made possible by direct negotiation between government and drug companies.

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Colorado

Continued from page 1

be "integrated" with a "covered person's choice of care" and "efficacious interventions to maximize the quality and quantity of life for individual covered persons."

Critics say that in practice such language subordinates patient wishes to treatment decisions made by an unknown "health care provider" using an undefined standard for "efficacious intervention." In practice, a patient's wishes will have only as much weight as the unnamed unaccountable all-powerful integrator decides to give them.

Those in favor of compulsory evidence-based guidelines say imposing their standards on physicians will lower overall health care costs by improving clinical treatment. In their view, waste and unnecessary expenditures will be controlled by the requirement that physicians conform to guidelines developed by committees after a review of the latest findings from randomized controlled trials using statistical controls to help sort out imperfect human perceptions of causality.

Some proponents put so much faith in trials that they confidently dismiss evidence gathered by means such as case reports and clinical observation. "If you find that [a] study was not randomized," the authors of one book on practicing and teaching EBM advise readers, "we'd suggest that you stop reading it and go on to the next article."

Those critical of EBM programs argue such mandates are unnecessary, because physicians rapidly adopt new treatments once the evidence in their favor is clear and convincing. They also say requiring the use of guidelines developed under EBM protocols gives too much power to small committees of experts who are human and may make mistakes.

Questionable Data

Expensive and difficult to design, randomized controlled trials are often "underpowered," meaning their sample sizes are too small to detect any but very large differences between treatments. Underpowered trials are more likely to find no difference between old and new treatments, an outcome that makes it easier to justify some kinds of rationing decisions.

Weaknesses in study design, some of which are not well understood until the results have been reported and picked over by the scholarly community, also cause problems. And because trials take so long to carry out, the treatments they test and the guidelines developed from them are often outpaced by medical progress.

The seven-year-long Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT) study carried out by the National Heart, Lung, and Blood Institute at a cost of $125 million is a case in point. Designed to compare how well four drugs prevented death in people with high blood pressure, its results found no difference between the effect of a simple diuretic and a newer, more expensive, ACE inhibitor.

Though the Institute subsequently published U.S. guidelines stating that first-line treatment for people with high blood pressure should be a diuretic, alternative interpretations of the ALLHAT study pointed out that roughly one-third of the sample was African-American, that African-Americans are known to be relatively unresponsive to ACE inhibitors, and that all-cause mortality for Caucasians was lower in the ACE inhibitor group than in the diuretic group. One British scholar noted that the antiquated drug regimes specified for ALLHAT would "more commonly [be] found in a pharmaceutical museum than in our patients."

Other scholars noted ALLHAT suffered from inadequate power, lower than projected sample size, and poor compliance. Michael A. Weber, a hypertension specialist at New York's Downstate Medical Center, also pointed out, "although not presented in the ALLHAT report, the relative cost of drugs somehow became part of its published conclusion."

In the United Kingdom, where the National Institute for Clinical Excellence (NICE) promulgates evidence-based guidelines for the National Health Service, cost savings have not materialized. NICE itself estimates that it added an estimated £575 million in costs to the National Health Service budget in its first two-and-a-half years of operation. And centralized control of clinical treatment also introduces a new ethical dilemma for physicians.

The Double Lie

As a 2000 editorial in the *British Medical Journal* put it, evidence-based programs that force centralized control on clinical medicine live a double lie.

The first lie is that EBM is not about rationing, because it supposedly doesn't count as rationing if you are denying ineffective interventions.

The second and related lie is to "give the impression that if the evidence supports a treatment then it's made available, and it if doesn't it isn't. In other words, the whole messy problem of deciding which interventions to make available can be decided with some data and a computer."

The editorial concludes that to believe this is to ignore the fact that risk matters. In reality, deciding what constitutes cost-effective treatment for a given patient is an ethical judgment, not a mere technical problem.

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Rx Buying Clubs Not Always Cheaper

by Steve Stanek

Budget pressures, clamoring from senior citizen groups, and a recent favorable court ruling have prompted a number of states to create "drug buying clubs" and take other measures to cut prescription drug costs.

In Illinois, for example, the Rx Buying Club for disabled persons and those who've turned 65 years old went into effect January 1. The club is part of an initiative that combines the buying power of nine state agencies to negotiate lower drug prices. Illinois last year spent about $1.8 billion on prescription drugs for state employees and retirees and beneficiaries of Medicaid and other public health programs.

Within three weeks of its effective date, the Illinois Rx Buying Club had received more than 61,000 requests for applications, according to Nikki Smith, public information officer for the state's Department on Aging, which oversees the program. More than 5,000 applications with the annual $25 fee were returned during the program's first 20 days, she said.

Not Always Cheaper

Illinois Rx Buying Club participants pay a $25 annual fee that is waived for low-income residents. About 2 million seniors 65 and older, disabled people, and state employees and retirees may join. State officials predict Illinois will save $120 million a year through larger drug discounts negotiated by the program.

But at a ceremony at a Chicago-area senior center to promote the program, Blagojevich handed out information sheets with drug club prices. The *Chicago Tribune* contacted several pharmacies and found certain common medicines would cost less at retail than through the drug buying club.

For instance, 30 capsules of the acid reflux drug Nexium would have cost $124.19 through the buying club, but $119.99 at Walgreen's. The cholesterol-lowering drug Zocor would have cost $125.88 for 30 tablets through the drug buying club versus $114.99 at Walgreen's. Some drugs did cost less through the drug buying club than the advertised retail prices at Walgreen's and other major drugstores.

Popping Up All Over

The recent state drug club activity stems from a Supreme Court ruling issued last summer. By a 6-3 vote, the justices rejected a challenge to a Maine plan to extend drug discounts to non-Medicaid patients. Drug makers and other plan opponents argued the plan interfered with interstate commerce because it would have penalized companies that refused to participate.

In Ohio, the new Golden Buckeye Prescription Drug Savings Program negotiates drug discounts with local pharmacies and passes on manufacturer rebates to participants. It also provides a free drug utilization review process for participants who are taking multiple medications. About 1.7 million Ohioans who are at least 60 years old and do not have prescription drug coverage qualify for the program at no cost. So do another 300,000 persons between 18 and 59 years old with total and permanent disabilities.

The Wisconsin Rx plan, a coalition of businesses and the state's largest teacher union, on January 1 began negotiating discounts for its 260,000 members of up to 15 percent on prescription drugs from U.S. drug chains. The state also has established a Web site to help residents buy drugs from Canada.

Minnesota already has the Prescription Drug Program, which provides prescription drugs to low-income seniors and disabled persons who are ineligible for full medical assistance and who have been at least four months without prescription drug coverage. Participants must pay a monthly $35 deductible before program benefits kick in. Other states, including Alaska, Maine, and Washington, are considering similar measures.

It's the Budget

Illinois has a multi-billion-dollar budget deficit, and Blagojevich has made the cost of prescription drugs a major focus of his administration's effort to bridge that gap. He has lobbied heavily but unsuccessfully for the federal government to allow Illinois to import drugs from Canada, where price controls and economic factors make most drugs less expensive than in the United States.

Blagojevich also has sent letters to other governors encouraging them to lobby for their states to be allowed to reimport drugs.

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California Play or Pay Repeal Gains Ballot Status

by Conrad F. Meier

A three-judge panel of the First Circuit Court of Appeals in San Francisco has ruled Californians should be allowed to vote on a referendum aimed at repealing SB 2, a law requiring some companies either to provide health insurance to their workers or pay into a state fund that would provide such coverage. The measure is expected to appear on the November ballot. (See "Cal. Insurance Mandate Faces Repeal," *Health Care News*, January 2004.)

The appeals court ruled in early February that a Sacramento County Superior Court judge wrongly decided in December that the title and summary statements on petitions circulated to place the referendum on the ballot contained "misleading and prejudicial" information and that the petitions themselves were technically flawed.

The appeals court said the title and summary can be "reasonably read to accurately describe the 'chief purposes and points'" of the new law and that the organizers' failure to print the title of the measure on each page of the petition was "not confusing or misleading."

Last December, Californians Against Government Run Healthcare, a coalition of business groups led by the California Chamber of Commerce, announced it had collected more than 620,000 signatures to place the referendum on the ballot. Governor Arnold Schwarzenegger (R) is on record as supporting the referendum.

Several groups, including the California Labor Federation/AFL-CIO, challenged the repeal effort, complaining the petitions misrepresented a provision of SB 2 that exempts businesses with 20 to 49 employees from the program until the state provides them with a tax credit to offset some of the costs of providing health coverage.

Education Effort Underway

Former Governor Gray Davis (D) signed the play or pay mandate in October just two days before he was recalled from office.

The mandate, scheduled to take effect January 1, 2006, forces employers with 200 or more employees to provide health insurance to employees and their dependents or pay into a state-run health insurance plan. Businesses with 50 to 199 workers will be forced to offer health insurance only to employees by 2007; and employers with fewer than 20 workers will be exempt from the law. Those with 20 to 49 employees will be exempt from the law unless the state provides tax credits to subsidize the cost of health benefits.

"John Dunlap, CEO of the California Restaurant Association, told the *San Jose Mercury News* the $10 million campaign will include television ads and direct mail pieces."

Employers who already offer health benefits that comply with the mandate can continue offering their existing benefit plans. If those plans do not comply with the mandate, employers can be fined. Sara Lee, vice president of media relations for the Chamber of Commerce, predicted, "When voters are truly aware of what [SB 2] means, they will reject it." Lee said business groups plan to launch a campaign to educate voters about the law and help them "understand the severe impacts that this multibillion-dollar mandate will have on California jobs."

John Dunlap, CEO of the California Restaurant Association, told the *San Jose Mercury News* the $10 million campaign will include television ads and direct mail pieces. According to the *Mercury News*, a coalition of physicians, consumer groups, and labor unions is expected to launch a "vigorous" campaign against the referendum.

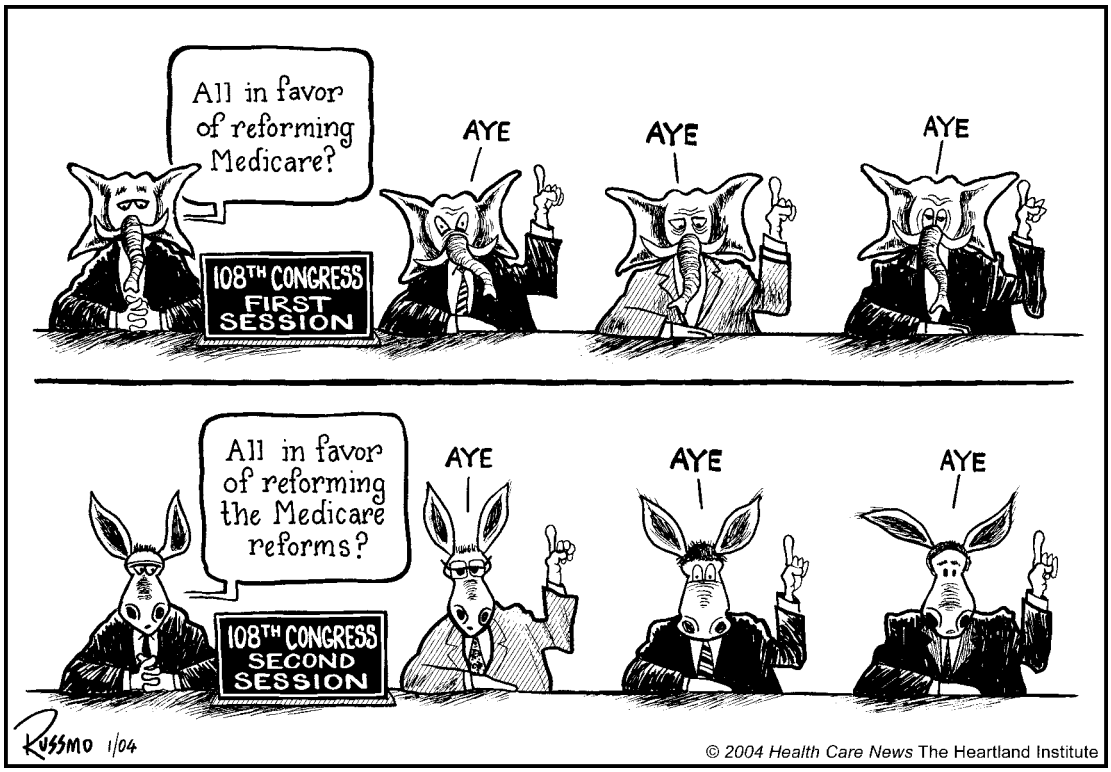
Public Opinion Unclear

A telephone poll of 929 California registered voters, conducted by Field Research, found 65 percent of voters support the play or pay mandate, while 27 percent oppose it and 8 percent are undecided. After those surveyed were briefed on the mandate's provisions and expected impact, support fell to 53 percent; 39 percent opposed the mandate and 8 percent remained undecided.

"The California Labor Federation maintains labor union polling shows 71 percent of California voters support the law," said Mark DiCamillo of Field Research. "What this says to me is that this is going to be a very contested initiative."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

RUSSMO'S **RANT**



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CDHCC and Boomers Conferences to Co-Locate in Las Vegas

by Marian Johnson

Two of the nation's premier health care conferences—the Consumer Directed Health Care Conference and Expo (CDHCC) and the Boomers Business Conference and Expo—will co-locate in Las Vegas, Nevada at the Las Vegas Hilton on March 29-31.

Health Care News is a media sponsor of both events.

CDHCC provides a forum for providers, health plans, and policy makers to express ideas about market development trends and issues. Attendees will have the opportunity to explore topics that include emerging consumer-directed health care models and national health care policies focused on the aging workforce. CDHCC sessions also will cover critical issues relevant to today's health care climate, including rocketing health care costs, maintaining the quality of patient care, and the current legislative and regulatory landscape.

The Boomers Business Conference and Expo highlights the strategic planning necessary to appropriately address the rapidly growing Boomer population, aiming to help attendees jump-start their initiatives into the lucrative Boomer marketplace. Expert speakers representing all industries will be on hand to get attendees in sync with this powerful market. Lifestyle, health care, and financial and retirement funding considerations will be addressed, and there will also be a session on technologies transforming health care retirement.

The co-location of the two conferences offers attendees simultaneous access to the latest updates and strategies in consumer-directed health care and the Boomer market.

Marian Johnson is a public affairs representative for the two conferences. Her email address is **marian@cdhcc.com**. *For more information about the conferences, visit their respective Web sites at* **http://www.cdhcc.com** *and* **http://www.boomers.com**.

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DESTROYING INSURANCE MARKETS

2nd in a series

HEALTH INSURANCE Meltdown IN VERMONT

by Conrad F. Meier

During the early 1990s, many states adopted regulations requiring health insurance companies to accept anyone who applied for coverage and charge everyone within each group the same rates regardless of their age, gender, lifestyle choices, or health status. These regulations, called guaranteed issue and community rating (see below), were intended to force healthy people to subsidize less-healthy people, and to make it easier for people without health insurance to get back into the system.

Eight states—Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington—imposed community rating and guaranteed issue on health insurance companies that sell to *individuals* as well as to groups. Their decisions, controversial at the time, have had a major impact on the health insurance marketplaces in those states.

The following case study is the second in a *Health Care News* series (the first, published in February 2004, addressed New Jersey) documenting how community rating and guaranteed issue have destabilized and sometimes destroyed the private individual insurance markets in states that adopted such legislation.

Guaranteed Issue

Guaranteed issue (GI) laws forbid health insurance companies from denying coverage to anyone who applies for health insurance, including those individuals who apply for insurance after the onset of a chronic health condition or who have made lifestyle choices known to be unhealthy. Adopted to help end "job lock," GI has the unintended consequence of encouraging people to wait until they get sick before buying health insurance, which increases the number of uninsured and the premium costs for those who remain insured.

Community Rating

Pure community rating (CR) laws require health insurance companies to charge the same premium to everyone, regardless of age, sex, health history, lifestyle choices, and regional demographics. This one-size-fits-all rate results in charging young and healthy people higher premiums than their expected medical expenses would otherwise justify in order to subsidize rates for middle-aged, older, and less-healthy people.

Under "modified" CR, premium variations are allowed to compensate for certain risk characteristics such as age, sex, and family size, but not for others such as health status or lifestyle choices.

Former Vermont Governor Howard Dean, a physician now running for the Democratic Party's nomination for President, considers his state a model for health care reform.

"In Vermont, where I served as governor for the last 11 years, nearly 92 percent of adults now have [health insurance] coverage," boasts Dean's campaign Web site. "Most importantly, 99 percent of all Vermont children are eligible for health insurance and 96 percent have it."

Universal health care—more accurately, universal health insurance—has been a Dean rallying cry for more than a decade. In 1992, his first year as governor, Dean pushed through to passage Act 160, which created the Vermont Health Care Authority and charged it with bringing forth two sweeping health care reforms: a single-payer plan Dean had championed in 1991 as lieutenant governor and a measure he dubbed "regulated multi-payer."

Dean's effort to make health insurance universally available in Vermont has in many ways backfired. What has become "universal" in the state are high health insurance premiums and a heavy tax burden needed to support the growing number of Vermonters covered not by private insurance but by government-run Medicaid. Moreover, the number of uninsured Vermonters has increased, not fallen, since Dean's reforms took effect.

Legislative Mischief

In 1991, the Vermont legislature passed Act 52, mandating guaranteed issue and community rating of insurance policies issued in the small group market. This caused young, healthy worker groups to face startling increases in premiums, since their age could no longer be taken into account in determining their risk. Many small businesses dropped their newly unaffordable plans and sent their employees to buy policies in the individual market. To close this "loophole," the legislature followed up with Act 160 in 1992, extending the guaranteed issue and community rating mandates to insurers offering policies in the individual market.

By law, insurers are prohibited from using medical underwriting to set premiums. The state's insurance commissioner initially permitted commercial insurers to deviate from a community-rated premium by 20 percent, but did not permit BlueCross/BlueShield (BC/BS) or Community Health Plan (CHP), the state's original nonprofit HMO, to deviate. For several years, BC/BS lobbied for a change in the regulation. Effective January 1, 2000, the commissioner eliminated the rate deviation for all newly sold policies and phased out the deviation on all existing policies for the few remaining carriers. Vermont now has the most absolute community rating—zero deviation—in the country.

More Uninsured

Community rating and guaranteed issue have wreaked havoc on Vermont's small group and individual insurance markets, just as they have in states across the country. The percentage of the state's population that is uninsured has increased, not fallen, since the mandates were imposed; premium rates have increased; and more Vermonters than ever are having to settle for government-run Medicaid in order to get insurance. Vermont is now second in the nation, after Tennessee, in the proportion of its under-65 population covered by Medicaid (21 percent).

Dean boasts that the share of Vermont's population without insurance fell during his tenure. In June 2000, an 11-member panel of state officials reported the percentage of the state's population that is uninsured had fallen from 10.8 percent in 1993 to 6.8 percent in 1997.

But those figures do not square with statistics compiled by the U.S. Census Bureau. In a November 19, 2002 Ethan Allen Institute commentary, John McClaughry, the group's president and a member of the Vermont Senate between 1989 and 1992, noted, "According to Census Bureau figures, [the uninsured rate in Vermont] has gone from 9.5 percent (1992) to 9.7 percent (averaged over 1999-2001). In 1994 ... that data series ranked Vermont second among the states. The 2001 ranking for health insurance coverage placed Vermont 10th in the nation."

McClaughry acknowledges that due to the small sample size used by the Census Bureau's Current Population Survey, estimates of the uninsured pop-

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VERMONT continued

ulation can vary widely from year to year. In defending his Medicaid expansion in 1997, however, Dean touted his state's high ranking (second in 1994). The 1995 CPS, however, had dropped Vermont to 23rd. Dean did not acknowledge the new ranking.

Insurers Leave

According to State Rep. Frank Mazur (R-South Burlington), "former Governor Dean's community rating and guaranteed issue policy initiatives have driven out private insurers from Vermont."

About 25 percent of Vermont's private health insurance market—about 18,000 people in the individual market and 33,000 in the small group market—is subject to community rating. The remaining 75 percent of the market—associations, large groups, and self-insured companies—have premiums based on health underwriting and experience rating.

What was formerly a healthy and affordable individual and small group health insurance market boasting 33 competitive insurance companies is now a shell of its former self. Such highly regarded companies as Aetna, Fortis, Golden Rule Insurance, Kaiser Permanente, Nationwide, Trustmark, and, most recently, Mutual of Omaha, have all left a market known to be a hostile environment in which to do business.

Today the only significant player in the individual health insurance market is BC/BS. In 2002, BC/BS had 9,182 policies in force in Vermont's individual market, or 51.8 percent of the total. Mutual of Omaha had 8,275 policies. But with Mutual of Omaha's departure, the only other entity actively selling individual health policies in Vermont is MVP Health Plan, Inc. MVP had only 120 policies in force in 2002.

The legislature clearly anticipated most insurance companies would abandon the state when it legislated guaranteed issue and community rating in 1992. As carriers left Vermont, their insureds became eligible for a "safety net" established by the legislature. The safety net's key provisions:

- Health insurance must be made available to persons whose "insurer withdraws from the marketplace in Vermont."
- BC/BS is required to provide safety net coverage at "substantially similar terms and prices" as what the insured originally had.
- "Substantially similar prices" is defined as prices identical to those paid by the insured during the preceding year, adjusted for trend by an amount up to 15 percent. The legislation also allows additional annual adjustments of up to 15 percent, provided the insurer providing the safety net coverage has at least an 80 percent loss ratio. Finally, the insurance commissioner is authorized by the legislation to permit an additional 15 percent increase if BC/BS would be hurt without it.

"The percentage of the state's population that is uninsured has increased, not fallen, since the mandates were imposed; premium rates have increased; and more Vermonters than ever are having to settle for government-run Medicaid in order to get insurance."

For Whose Protection?

The legislative "safety net," alleged to be for the protection of Vermont's insured, appears to have worked more in favor of BC/BS.

In early 1994, BC/BS reported it would face a $6.2 million loss in 1994. Its surplus was down to $8.8 million, $7.1 million of which was its home office real estate.

BC/BS reported that its loss ratio for the safety net business for 1994 was 88.4 percent. Insurance industry analysts say that, allowing for a reasonable administrative load, the company likely had a profit on its safety net business. But BC/BS reported an underwriting loss of $1.4 million. It reported administrative costs twice that permitted by law. It then used a trend of 19 percent (unsupported in its rate filing with the state) to justify a rate increase of 37 percent for the safety net business.

That increase was approved by state officials in August 1995—apparently allowing BC/BS to use the safety net business to subsidize losses in its own business.

Premiums Rise

"In 1992, nearly everyone (except the insurance industry) held the euphoric belief that 'reforming' health insurance would be a piece of cake," wrote Ted Cote in the *St. Albans Messenger* on August 21, 1995. "The fact that Vermont is still wistfully enamored with a socialist/single payer scheme will likely guarantee continued failure."

Things have gone from bad to worse since Cote made his prediction in 1995.

According to Mazur, "a high-deductible ($2,250) individual insurance policy for a 33-year-old in Vermont currently costs $215 a month. In New Hampshire the policy costs $128 a month, and in South Carolina, $76 a month. Differences in population are a minor factor but community rating and guaranteed issue are major impediments to health insurance costs in Vermont compared to other states."

There is also significant variance in the cost of family health insurance plans. In a 2001 article for *Health Care News*, Mazur reported that in Pennsylvania, a family plan with a $1,000 deductible cost $190 a month; in Connecticut, $230 a month. In Vermont, such a policy would cost more than twice as much, $543 a month.

"Insurance premiums are sky high," writes physician David Gratzer, a senior fellow at the Manhattan Institute, in the January 12, 2004 issue of *The Weekly Standard*. "'I'm paying a lot and getting little choice,' a self-employed Burlington resident told me. He wasn't kidding: To cover his wife and himself, he pays $5,000 a year for a plan with a $1,000 deductible. Because most carriers have left the state, there are only a few insurance companies left in business."

Shift to Taxpayers

The premium increases led many younger Vermonters to drop their private-sector insurance coverage. Dean administration reformers stepped in, extending eligibility for Medicaid to a wider swath of the state's population. The program has been expanded to the point where children in a family of four earning three times the federal poverty level (now around $52,000) can get "free" health care from the state. The Dean administration actively promoted government coverage, urging parents to take their children off their private insurance and enroll them in the state program. Medicaid in Vermont has become a welfare program for the middle class.

According to Mazur, Dean's "attempt

Repeal Community Rating

by John McClaughry

A main tenet of modern liberalism is that government must take from those who have a lot, and distribute benefits to those who have little. Thus it is always baffling when liberals demand the poor be taxed to shower benefits on the rich. The latest example of this Robin Hood in Reverse policy is the liberal opposition to Vermont Gov. Jim Douglas's (R) plan to back off from strict community rating in health insurance.

Community rating says everyone buying health insurance must pay the same premium for the same benefit package, regardless of age, gender, or anything else that affects their health care costs.

Health insurance is the only type of insurance where community rating applies. In auto insurance, drivers with driving violations pay higher premiums. In life insurance, young people pay low premiums, and old people, soon likely to die, pay very high premiums.

Community rating of health insurance forces healthy young people to pay higher premiums to cover the elderly sick. That may seem charitable, but consider this: A young couple in their twenties is typically trying to pay for a home mortgage, cars, children, and often college loans. They are trying to meet these responsibilities when they are at the low end of their career income curve.

Their grandparents, by contrast, have long since paid off their educational loans, paid off their home mortgage, and seen their children grow up and leave the home, perhaps starting families of their own. The breadwinner, with 40 years of work experience, is usually earning his or her highest income.

So, the proponents of community rating propose to "fix" health insurance law so that statistically less healthy, but more wealthy, Grandpa and Grandma get the lower insurance premiums, paid for by their much healthier, less wealthy grandchildren. Does that sound fair or reasonable?

That's exactly what Vermont insurance law has required since 1992, when community rating was adopted to fend off the insolvency of Blue Cross and Blue Shield of Vermont.

The result was the destruction of the state's competitive health insurance market. Insurers who were marketing very affordable coverage to healthy young peo-

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for a 'universal' health care solution further expanded Medicaid to almost 25 percent of our population." McClaughry notes, "Eleven Dean years have now gone by. The state share of Medicaid spending has risen from $86.7 million to $263.5 million." Medicaid is a joint state-federal program, and federal taxpayers pay about $458 million for Vermont's generosity.

In spring 2002, the state's Joint Fiscal Office projected the state Medicaid plan will be $42 million in the hole by 2006, even with no new beneficiaries. In his January 2004 budget message, Gov. Jim Douglas, Dean's Republican successor, announced that if no corrective action is taken, the Medicaid deficit would come to $245 million by 2009.

Some observers have suggested Vermont's shift from private-sector to government-run insurance was not an "unintended" consequence of the Dean reforms at all. "The root cause of Vermont's problem came in the late 1980s," explained McClaughry, "well before the Dean era, when Blue Cross/Blue Shield of Vermont was threatened with insolvency. It used all of its political muscle to impose community rating and guaranteed issue on its competitors, who were taking away their customers.

"The competitors then obligingly departed the state," McClaughry continued. "Now, liberals stoutly defend a regressive single-payer health care, managed by Blue Cross/Blue Shield as a ward of the government."

In a 1995 letter to the editor of the *Hartford Courant*, Wallingford, Vermont resident John McTaggart wrote, "Instead of being rewarded for initiative and healthy choices, I have to be thrown in with a pool of many who did not conduct their health care and lifestyle in a manner similar to my own pursuits. Truth is the state wants individuals like myself to subsidize the rest of policyholders, and the way to get this done was to close the doors to insurance companies that rewarded better risk applicants."

Liberal Lawmakers in Denial

As the 2004 legislative session got underway in Vermont, some lawmakers continued to turn a blind eye toward the health insurance meltdown that has resulted from the state's misguided public policy actions.

State Sen. Rod Gander (D-Windham) told the *Brattleboro Reformer*, "Preserving Vermont's community rating law is a priority this session." Several of his Democratic Party colleagues agreed. State Rep. Richard Marek (D-Newfane) maintains, "Community rating has worked well in Vermont, although it's far from perfect."

Jeffrey and Charlotte Tullar are among many of the state's health care reform tragedies. The Tullars say they "never dreamed the state's fling at health care reform would cause them to lose their health insurance." Two years after the community rating and guaranteed issue mandates were passed, the Tullars faced a 170 percent premium increase. Their health insurance premium would have been more than their mortgage.

McClaughry notes, "Dean's policy was to drive out insurance companies, make ever more people dependent on government health care, underpay the providers, and replace personal responsibility with 'delivery of services.'"

Restoring the Free Market

In its 2004 Position Statement on Health Care, the Lake Champlain Regional Chamber of Commerce (LCRCC) encouraged policymakers to conduct a thorough review of the regulatory environment affecting the cost of health insurance in the state. The group also urged a movement away from community rating.

"It would be useful," stated the LCRCC, "to examine proposals for limited modifications in community rating. Some examples of modifications that could be looked at include allowing a 10 percent plus or minus rate band, geographic rating, industry rating, or personal health accountability factors."

"Two years after the community rating and guaranteed issue mandates were passed, the Tullars faced a 170 percent premium increase. Their health insurance premium would have been more than their mortgage."

The *Burlington Free Press*, the state's leading newspaper, editorialized in September 1995 that community rating had already failed and should be repealed. "It has the best of intentions, but has resulted in driving people who were paying their own way off insurance, and toward dependency on the state."

When Gov. Douglas was asked by reporters what measures he would implement to contain health insurance costs he replied, "First, I would revisit community rating to create more flexibility and competition in the health insurance marketplace. I would instead have a high-risk pool to subsidize those Vermonters who are uninsurable. I would work to end the Medicaid cost shift that passes the high costs of this program onto consumers of private insurance. I would reduce unnecessary government mandates and move toward Medical Savings Accounts so employers and employees could contribute to a special tax-free account to pay for high-deductible, low-premium health insurance."

"Douglas also advocated providing more information to consumers and insurance discounts for healthy behavior," said Mazur, which would appear to be a step away from community rating. "Most of his policy recommendations are included in H 196 and a subsequent bill that I introduced this year."

If Vermont is going to back out of the mess it has made for itself, acknowledging that misguided public policies are to blame would seem to be an important first step. Repealing community rating and guaranteed issue mandates should be high on the reform agenda. Mandated insurance benefits, which needlessly raise the price of insurance, should also be rolled back. Giving individuals who buy insurance the same tax breaks as those whose employers provide insurance is yet another promising reform.

Vermonters also should consider additional reforms being entertained in other states, including a functional high-risk pool, to address the needs of the medically uninsured and uninsurable without skewing the insurance market for everyone else, and paying the reasonable charges of physicians, hospitals, and other health care providers who provide services for the beneficiaries of state government health programs.

"I think many fear it's too much reform for the Democratically controlled state senate to accept," warned Mazur. Nevertheless, he acknowledged, small steps in the right direction are being made.

NEXT MONTH:
ESCAPE FROM NEW YORK

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ple abandoned Vermont, as the backers of community rating intended. Blue Cross, with considerable regulatory assistance, emerged from its near-bankrupt status to gain a near-monopoly on the small group and individual insurance markets in Vermont.

Worse than this bit of corporate welfare is the overall impact on health care policy. Robin Hood in Reverse community rating drives out competition and choice, and forces people who choose healthy lifestyles to pay for the problems of those who don't. If it is to be effective in the long run, any serious health care reform requires restoring personal choice and responsibility for health-affecting lifestyle choices, and market competition in care and risk protection.

In 1999, Gov. Howard Dean's insurance commissioner, probably without legal authority, removed the 20 percent premium variation allowed by the 1992 law and imposed the nation's strictest community rating principle: zero premium variation for age of the insured.

Douglas now proposes to roll back that rule. Liberal legislators have vocally protested. They are willing to ignore the awkward fact that community rating taxes the relatively poor to benefit the relatively rich. They correctly see any weakening of community rating as a step back from their goal of socialized medicine.

Douglas's customary caution may serve him badly in this instance. His proposed administrative rule change to expand the premium rating band is not likely to attract any more insurers to the state. It has, however, brought down upon the governor the wrath of single-payer liberals. Sen. Peter Welch, the Senate Democratic leader, was quick to call Douglas's proposal the single biggest mistake Douglas has made in office.

If Douglas is determined to lay the groundwork for health care reform based on responsibility, choice, and competition, he needs to do much more than roll back Dean's rating rule. He needs to persuade the people and their legislature to march off in a different direction. Repealing community rating outright, and allowing premium discounts for healthy lifestyles, are key items in a reform agenda.

"It's time for legislators to ... admit this was a big mistake, give community rating a decisive burial, and move on to craft a market-oriented reform agenda that will lead the nation."

Reviewing three years of community rating, the *Burlington Free Press* editorialized in 1995: "The 'community rating' law must be repealed. It had the best of intentions, but has resulted in driving people who were paying their own way off of insurance, and toward dependency on the state. Lawmakers should be bold enough to admit a failure. The plan was a fine piece of economic theory—as supporters, we share in the guilt—but reality has proved smarter."

Eight more years have gone by. It's time for legislators to do what the *Free Press* bravely did: admit this was a big mistake, give community rating a decisive burial, and move on to craft a market-oriented reform agenda that will lead the nation.

John McClaughry has been president of the Ethan Allen Institute since its founding in 1993. He is a former fellow in the Institute of Politics at Harvard University's John F. Kennedy School of Government; a senior policy advisor in President Ronald Reagan's White House Office of Policy Development; a member of the Vermont Senate; and Republican candidate for governor of Vermont, 1992.

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Celebrating Consumer Choice

by Greg Scandlen

"We need a consumer-driven health care system. And we need better information about health care prices. A consumer-driven health care system with better information will help control the cost of health care. That's the rationale of the health savings accounts."

PRESIDENT GEORGE W. BUSH

The President of the United States has become the number one salesman and marketer for Health Savings Accounts (HSAs).

Grace-Marie Turner and I were honored to be among about 100 people to join President George W. Bush at a Washington, DC event on January 28, highlighting several employers and consumers who have already benefitted from HSA products. He called for malpractice reform, tax credits for low-income Americans, and more community health centers.

But the meat of his talk focused on Health Savings Accounts. He stressed HSAs will begin to educate consumers about the true costs of care and restore the patient-physician relationship. "We need a consumer-driven health care system," Bush said. "And we need better information about health care prices. A consumer-driven health care system with better information will help control the cost of health care. That's the rationale of the health savings accounts."

He went on to list some of the benefits of HSAs:

"First, many American families who choose HSAs will pay less overall for their health care. Secondly, HSAs will encourage people to spend wisely for their routine medical expenses. Third, HSAs will encourage people to save for their health care needs both now and in the future. Fourth, there is an incentive to take care of their bodies and live healthier lives. Fifth, HSAs will make it easier for some people who are now uninsured to purchase health insurance."

The President introduced several consumers who were illustrations of these various points. He went on to call for deductibility of HSA premiums and the establishment of Association Health Plans.

Thinking Outside the Box

The *Baltimore Daily Record* included an article by benefits attorney Becky Kukuk in which she notes, "The enactment of HSAs represents a further shift in U.S. health care policy toward consumer-driven health care."

She adds, "HSAs offer a flexible, tax-free savings vehicle to a growing segment of health care consumers." She cites the recent Kaiser Family Foundation study of employer benefits that "found that 17 percent of large employers (5,000+ employees) offered high-deductible health plans (and) 16 percent indicate they are likely to add a plan of this type in 2004."

Eva Rosenberg writes for CBS's "MarketWatch," "Finally, a tax-advantaged health care program that cuts across all income levels and lifestyles—the new Health Savings Accounts. They are a real boon for people who pay for their insurance coverage."

She cites Tim Bireley of Fortis Health as saying up to 40 million people will take advantage of them. She reports on a CPA in South Carolina who knows of one company that already has implemented an HSA and expects to save $65,000 in premiums in 2004. Also cited is Elise Koll of *Working Today* magazine, who says HSAs are "more than just portability in health care. They remove the employer-ownership of the plan and put control into the employees' hands."

AHPs—Is a Compromise Possible?

Speaking of Association Health Plans (AHPs), *USA Today* is frustrated that such a simple idea as small businesses joining together to gain better insurance rates has become so controversial. The paper agrees it isn't a panacea, "but (AHPs) would address an important problem: the steep costs small businesses must pay to offer medical coverage. Yet even this small, common-sense reform has touched off fierce opposition from powerful groups ranging from Blue Cross and Blue Shield to state health commissioners."

The article points out AHPs passed the House, but were held up in the Senate last year. The writer hopes the "pop from Bush's [State of the Union] speech and a commitment by Senate Majority Leader Bill Frist (R-Tennessee) to take up the matter as part of a broader health care package may brighten the outlook."

Uninsured Getting Political Attention

Writing in "AMNews," Joel Finkelstein reports, "Now more than ever, the problem of the uninsured must be addressed without delay. That is the unified message being delivered by politicians, special interest groups, voters, and academics across America." He cites the President's State of the Union address and quotes AMA President Donald Palmisano as saying, "The AMA is encouraged by President Bush's attention to the plight of the uninsured. We applaud the President's conclusion that 'a government-run health care system is the wrong prescription' for America."

The article goes on to mention the Democrats' opposition and the recent Institute of Medicine study concluding "the only satisfactory answer is universal coverage." The article also cites a recent survey done by Democratic pollster Stanley Greenberg for the American Hospital Association that ranks health care as tied with terrorism for the number two issue on the minds of voters. The economy is number one.

Maryland's Health Care Future

Maryland is one of the states wrestling with these issues. There are two competing proposals—one Republican and the other Democrat—for mandatory universal coverage.

The Maryland Public Policy Institute asked me to write a paper on what Maryland should be doing in health reform, and I decided a pox on both their houses was in order: "Covering the uninsured with more of the same insurance policies available in the state does nothing to correct what is wrong—and expensive—with those policies," I noted.

Maryland is one of the most highly regulated states in the country. It has more health care mandates than any other state, it has a Health Care Commission that has created a regime in which two insurers control 88 percent of the small group market, and it has an "all-payer" hospital rate control system and one of the most restrictive Certificate of Need programs in the country. It is the wealthiest state in the country, but has a worse record than most of its neighbors in assuring coverage.

All of these regulations serve to drive out competition and keep the local health care establishment fat and happy. Even Medical Savings Accounts were never allowed in the state, and it is unlikely the Health Care Commission will ever allow small employers to get their hands on an HSA.

My recommendation is to blow it all up. Get rid of all these regulations and allow competition and innovation back into the state.

Trouble in Paradise

Some states think the answer to rate increases is regulation. Hawaii is undergoing its first round of rate approvals since a new law requiring prior approval went into effect last year. The market is dominated by two carriers, Hawaii Medical Service Association (HMSA) and Kaiser, which are requesting increases of 9.7 percent and 14.5 percent, respectively, for limited blocks of business.

The primary effect seems to be delay of the increases while the insurance department deliberates. HMSA CFO Steve Van Ribbink says, "Regulation to me has nothing to do with the underlying health care costs other than the fact that it does add some administrative burden."

But a smaller competitor sees it as a much greater obstacle. Arnie Baptiste Jr., president of Health Management Alliance Association, says the process will add to rates due to the administrative burden. "The process is horrible. I have full-time staff people on this and I have attorneys working on this. We're spending an inordinate amount of money," he said.

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *His email address is* **gmscan@aol.com**.

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First HSA

Continued from page 1

lars, and as a self-employed person, I'm always looking for ways to save money.

"Being over 50, faced with the reality of having potential higher health care costs, it's nice this money can be in this account and used for that. If I don't need it, I can pull it out after 65 to pay for non-medical bills."

Wimbish, a wholesale furniture manufacturer representative, nicely summed up key provisions of HSAs, which were approved last December by Congress as part of the Medicare Prescription Drug, Improvement, and Modernization Act.

HSAs make health insurance more affordable by allowing consumers to save money in a tax-free account to pay for health care costs. Individuals with self-only policies can make a pre-tax annual contribution of $2,600, while families can make an annual contribution of up to $5,150, into an HSA.

"The recent passage of the Medicare reform legislation is a critical moment for health care in America. Included in that legislation are Health Savings Accounts, an innovative approach to paying for health care in which consumers are offered more flexibility, choice, and tax advantages," said Speaker of the House J. Dennis Hastert (R-Illinois), sponsor of the legislation. "This is an extraordinary step in the ever-changing landscape of health care in our nation that will give people more options and affordability in making their health care decisions."

"This was a no-brainer. One hundred percent of the deductible can go to the HSA for any medical expense, even ones that may not be covered by the policy. It's funded with pre-tax dollars, and as a self-employed person, I'm always looking for ways to save money."

PAMELA WIMBISH

Bring it Home

As an Aurora resident, Wimbish is one of Hastert's constituents, a point not lost on Kerry Smith, director of government relations for Fortis Health.

"We were thrilled that the first policy was issued in Speaker Hastert's district, because he was such a big part of this legislation," Smith said. He said the company had received more than 1,000 HSA applications in the first two weeks of January.

Fortis Health, which owns Fortis Insurance Company, Fortis Benefits Insurance Company, and John Alden Life Insurance Company, is one of the nation's leading health insurers, with more than 150,000 agents in 43 states. The company also has agreements to sell health insurance through other insurers, including State Farm, the nation's largest property-casualty insurer.

Fortis was one of the few health insurers to sell Medical Savings Accounts (MSAs), which Smith said were kept from taking off in a big way because of restrictions imposed by Congress. In February 2003, Fortis started working with Congress to expand MSAs.

Nobel Laureate Milton Friedman, speaking by satellite, defends Health Savings Accounts before an audience of more than 1,000 attending the 2004 World Health Care Congress (WHCC), conducted January 25-27 in Washington DC.

Conrad Meier

Not for "Runny Noses"

HSA policies typically feature high deductibles, which result in low monthly premiums. Wimbish said her coverage costs $250 a month with a $2,550 deductible.

"I don't look for insurance to cover every runny nose," she said. "If I'm in an accident or need surgery or something major, that's what I look for insurance to cover. My out-of-pocket costs, checkups and everything, are probably less than $1,000 year. The premium savings makes it worth it."

Scott Leander, the Fortis agent who sold Wimbish her policy, said he has the endorsement of the International Home Furnishings Representatives Association, to which Wimbish belongs. As a Fortis representative, he was able to offer them MSAs.

"I would show them a typical PPO with co-pays and MSAs, and most of them would choose the MSA, and now we have HSAs," Leander said. "Because there was legislative ambiguity with MSAs, that caused hesitancy with many insurance companies. They didn't think they would be something that would last."

Consumer Power

"Now with HSAs," Leander continued, "they're going to get involved. HSAs are getting to the way insurance was meant to be.

"We have auto insurance against catastrophic accidents. We don't insure against oil changes and tune-ups," Leander pointed out. "We don't insure homes against furnace cleanings. We insure against fire. Those managed-care plans, with their $20 co-pays and free doctor visits, are like insuring against tune-ups and furnace cleanings."

Wimbish said as the amount of money in her HSA account grows, she will likely purchase higher deductibles to drive premiums even lower.

That is the kind of thinking Smith and Fortis executives want to hear.

"The more you pay for insurance, the more you want to use it," Smith said. "That culture will bankrupt the system. We believe that with high deductibles as part of HSAs, we will see a dramatic change in how health care is delivered in this country."

He said with HSAs being tax-free and allowed to accumulate over time, and with no penalty for withdrawing HSA money for any purpose after retirement, it is actually a combination health insurance and retirement vehicle.

"It's a myth that this is only for the young and healthy," he said. "Data does not support that. Our average MSA customer is a couple of years older than the typical client. It's a financial product attached to health insurance. People in the individual and small-employer market buy insurance on need. If it's part of an investment, they tend to keep it. That promotes a positive insurance pool across the country."

Smith said Fortis' next effort probably will be directed toward helping the uninsured.

"We can help people through high-risk pools, through tax credits for the purchase of private coverage," he said. "We're going to push hard for those kinds of things to solidify the private market."

Steve Stanek is an Illinois-based freelance writer. His email address is **stanek@mc.net**.

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Any Doctor with a DEA License:

Throughout the United States, physicians are being threatened, impoverished, de-licensed, and imprisoned for prescribing in good faith with the intention of relieving pain.

The "War on Drugs" has come to mean a war on lawful drugs – and against the doctors who prescribe them and the patients who take them.

Prosecutors make careers out of high-publicity cases involving the hot drug du jour such as OxyContin.

But this war is causing enormous collateral damage and deaths from friendly fire.

Physicians have been drummed out of practice, sent to jail, and even been driven to suicide in the face of these 21st century witch hunts.

If this continues, not one doctor will be willing to prescribe the drugs that patients so desperately need

The real problem is not drugs, but drug *misuse*.

"PROJECT: COMMUNICATE AND COOPERATE"

AAPS 3-POINT PLAN TO STOP THE DRUG WAR ON PHYSICIANS & REDUCE Rx DRUG ABUSE

Tucson physician Jeri Hassman, M.D., and the AAPS have developed the 3-point *"Communicate and Cooperate"* campaign to encourage physicians and law enforcement to work together to prevent prescription drug abuse.

- Work together to track and report potential drug abusers.
- Joint reviews of potential cases before charges are filed.
- Mutual training to advise law enforcement of current trends and cutting edge treatments.

Every physician who holds a DEA license should be on alert.

Details of *Project: Communicate and Cooperate* are posted on the AAPS website.

Also, be sure to read *Advice to Physicians Re: Pain Management.*

What you can do:

1. Report problems to AAPS

2. Write Members of Congress (Sample letter online)

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Minnesotans

Continued from page 1

seems to be strong support for universal insurance backed up by a willingness to pay for it. You could argue that, politically, the people do support universal insurance."

Define Universal

Public support for universal health care, however, appears to depend on how the term is defined.

Fifty-six percent of the telephone survey's respondents supported a universal health care system in which the government guarantees health coverage. Forty-four percent favored a private system that relies on individuals and employers to provide for their own health care needs.

Authors of the Forum report caution, however, that "the strength of the preference [for a universal system ensured by the government] is questionable." Fifty-five percent of those who reported favoring government-run health care said they would reject such a system if it would limit their choice of doctors. Forty-one percent would reject government-run health care if it would create waiting lines for some non-emergency treatments. The term "non-emergency treatments" was not defined. In Canada, cardiac conditions can be classified as non-emergency, leaving patients to wait months for bypass surgery.

Other key findings:

- While 50 percent of survey respondents said they are dissatisfied with the cost of health care and health insurance, only 9 percent are dissatisfied with the quality of their health care.
- Only 5 percent are uninsured. Eighty percent agreed it's important to provide health care coverage for all Americans, even if doing so means raising taxes.
- 94 percent want to choose their own physician.
- 81 percent want the government to "do something" to reduce the price of prescription drugs.
- 18 percent said people have the right to use as much health care as they want, while 82 percent agreed with the statement, "People have the responsibility not to overuse health care services because it increases insurance costs for everyone else."
- 34 percent of households with a disabled person prefer a private system that relies on individuals and employers to provide for their own health care needs.

The survey also exposed inconsistent public attitudes regarding personal behavior, cost, and treatment decisions:

- While 62 percent of the respondents said people who smoke or do not exercise should pay higher insurance premiums, only 39 percent agreed that people who are likely to use more health care should pay higher premiums.
- Although 72 percent said the cost of treatment, along with the chance of success, are factors that should be considered in decisions regarding treatment, 67 percent said health insurance should pay for any kind of medical treatment, regardless of the cost. Sixty-two percent of respondents agreed with the statement, "Our health care system should spend as much money as necessary to try to save a person's life."

Core Values

The Forum's report identifies a list of "core values" about the health care system that panel members say are shared by most Minnesotans, and thus "should form the foundation of Minnesota's health care system":

- accessible to all
- fair
- safe, high-quality care
- personalized
- promotes health
- affordable
- rewards personal responsibility
- understandable

Survey respondents weren't presented with the list of values and asked to vote on them; rather, the list represents the panel's interpretation of what respondents meant by their answers to the survey questions. Moreover, the panel does not define what it means by each of the values. It is thus difficult to determine the depth of the public's support, or how they would prioritize and choose among competing or contradictory values.

Preferred Solutions

In addition to the core values list, the panel developed a list of the public's "preferred solutions," based on responses submitted through an online survey (108 responses), email and letters (58), and at town hall meetings (474 attendees). Creating a cumulative composite from all sources, the panel found the top 10 solutions, or problems in need of a solution, to be:

- early intervention/prevention
- drug pricing/costs
- administrative costs and delays
- single-payer health care
- consumer-driven health care
- evidence-based medicine
- chronic disease management
- purchasing pools
- malpractice and tort reform
- universal health insurance

At the town hall meetings, proposed solutions were solicited from meeting attendees and written on flip charts. The panel did not keep track of whether the solicited solutions came from unaffiliated citizens, spokespersons for advocacy groups, or members of the health care industry.

Each participant in the town hall meetings was given four stickers to vote for his or her four preferred solutions, making 1,896 total possible votes. (474 attendees x four votes each)

Attendees were not prevented from using more than one vote on any one proposal. Moreover, only 943 (49.7 percent) of the 1,896 possible votes were in fact cast, leaving substantial doubt as to the strength of town hall participants' support for any of the proposed solutions.

As this story goes to press, the panel is expected to release a second report on February 23, along with suggested solutions from the health care industry and panel recommendations for action. The Minnesota legislature opened its 2004 session on February 2 and may consider including the recommendations in pending legislative proposals.

Twila Brase, R.N. is president of Citizen's Council on Health Care, St. Paul, Minnesota, and a contributing author to Health Care News. *Her email address is* **twila@cchc-mn.org**.

Obesity Epidemic: Peter Jennings Is Wrong

by Harold M. Koenig, MD

Peter Jennings said on his recent ABC Special Report on Obesity that U.S. agricultural policies and the food industry are making our kids fat.

Peter Jennings is wrong.

When I was a kid I played outside a lot. After school, if it wasn't raining, I'd play outside until it got dark, dinner was ready, or it got cold. The backyard, an empty lot, or the street was my playground. I rode my bike two miles to and from school every day from third through ninth grade.

In elementary school we had an hour of physical education class every day, plus an hour at noon to play after we gobbled down our lunch. We had morning and afternoon 10-minute recesses that we spent on the school playground.

In junior high, seventh to ninth grades, we had one hour of gym class every day. It was compulsory; the only way we could get out of it was with a doctor's written excuse. At lunchtime we had organized intramural sports; though not compulsory, most kids participated. For the jocks we had "varsity" sports after school. The school district provided "late" buses for the kids who participated in after-school activities and rode the bus.

In high school, 10th to 12th grades, we still had compulsory gym class, even for the jocks. Riding bikes to school was considered kid stuff by then. Most students either rode the school bus or walked, and a few eventually got their own cars. That was too expensive for most kids, though.

My college required 14 semester hours of physical education credit to graduate. I don't remember any fat kids in college. I never knew a kid with diabetes. I thought it was an old person's disease.

In medical school I learned there were kids with diabetes, but they always had a kind called "juvenile" or type-1 diabetes. It was pretty rare. Juvenile diabetes was much more difficult to manage than the common form in adults, called "adult onset" or type-2 diabetes. Adult onset diabetes often could be managed with weight loss and dietary control. Kids always had to take insulin shots.

Over the last three decades, obesity has reached "epidemic" proportions in America's kids. The incidence of diabetes in kids has increased, but the increase is all accounted for by the adult form, or type-2 diabetes. In all the years I practiced pediatrics I never saw a kid with type-2 diabetes.

Pediatricians tell me today half the kids with diabetes have type-2 diabetes. They have it because they are too fat. They will have it the rest of their lives, and because they have it their lives will almost surely be shorter than they would be otherwise, and they will suffer a lot more morbidity.

Kids are too fat today because they no longer get enough exercise. Today the average American kid spends 95 percent of his or her time indoors. Indoors, kids are told from an early age to "sit still, be quiet, and don't run or jump." Yet that is exactly what kids need to be doing to grow and develop normally.

Many schools, for economic reasons, have cut out gym class and after-school sports. Kids who stay after school now go to the library or study hall. Kids who go home can't play in the street and there are few parks or playgrounds for them. They stay inside where they can't run, jump, or get much exercise. They have learned to sit still and be quiet, watching the "boob-tube," playing on the computer, or talking on their cell phones. And they eat.

Dr. Harold M. Koenig is a former surgeon general of the U.S. Navy and currently serves as president and chairman of The Annapolis Center for Science-Based Public Policy. This article was first published by Cybercast News Service, December 12, 2003 and is reprinted here with permission.

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Plummet

Continued from page 1

care plans a larger role in the program. How much to pay the private plans was one of the most contentious issues in the Congressional debate over the bill.

Market Reaction

Pacificare Health Systems Inc., of Cypress, California, the largest provider of Medicare HMOs, announced premium reductions and enhanced benefits for most of its 700,000 enrollees in eight Western states: Arizona, California, Colorado, Nevada, Oklahoma, Oregon, Texas, and Washington.

Aetna, of Hartford, Connecticut, also announced it would use the higher reimbursement payments to help many of the company's 121,000 enrollees in California, Maryland, New Jersey, New York, and Pennsylvania.

Health Net Inc., of Woodland Hills, California, made a similar announcement in January regarding its 171,000 participants in Arizona, California, Connecticut, New York, and Oregon. Insurers in Rhode Island also have announced plans to reduce the cost of health insurance.

The *Pittsburgh Post-Gazette* reported the Pennsylvania insurer, Highmark, is slashing premiums by as much as 64 percent. The rollback, effective March 1, means monthly premiums for Medicare HMO beneficiaries in the Security Blue Basic plan will drop from $56 a month to $20 a month, well below where they were in 2003.

Grace-Marie Turner, president of the Galen Institute, citing an Associated Press report describing premium cuts in Massachusetts, notes the three largest HMOs serving the state's Medicare population plan to reduce premiums between 36 and 48 percent.

"The sharpest decrease," wrote Turner, "will be for members of Blue Cross's Medicare plan, where premiums will drop from $162 to $84 a month. The company said it would apply all of the new revenues it is getting from the government to lowering premiums."

But cutting premiums isn't the only cost savings reaction to Medicare reform. Insurers are also beefing up benefits by reducing or eliminating co-pays and deductibles, adding previously unreimbursed medical treatments, and increasing payments to physicians and other care providers who serve seniors.

Federal Reimbursement Rates Increase

The Medicare reform measure established a new formula for determining payments to HMOs, resulting in an immediate payment increase of 10.6 percent. The Congressional Budget Office estimates the extra payments to private plans under the new formula will exceed $500 million this year and will total $14 billion between 2004 and 2013.

Many Republicans—and consumers as well—say private plans are more efficient than the traditional government-run Medicare program. While Democrats insisted private insurers would not save money for taxpayers, the resulting decreases in insurance premiums suggest otherwise.

Karen M. Ignagni, president of the American Association of Health Plans (AAHP), a lobbying organization for insurers, welcomed the increase in Medicare payments. The money, Ignagni said, establishes "a solid foundation for the broader modernization of Medicare" envisioned by Congress.

"The process of stabilizing and ultimately enhancing private-sector Medicare is well under way," Ignagni said. In addition, she noted the 10.6 percent figure was an average, explaining to the Associated Press some health plans would receive larger increases in parts of the country where Medicare has been paying less for seniors in the traditional fee-for-service program.

Ignagni mentioned other areas of the country that would receive above-average increases, including Nassau and Suffolk Counties in New York; Bergen County, New Jersey; Mercer and Delaware Counties in Pennsylvania; Jefferson County, Missouri; Riverside County, California; and Dallas, Texas.

Many of the 4.6 million Medicare beneficiaries who are enrolled in managed care plans had seen steady premium inflation and cuts in services since 1999. As many as 2 million older Americans lost their HMO coverage as insurers withdrew from the market because Medicare reimbursements have trailed rising health care costs, increasing an average of just 2 percent in 2003.

The higher government payments are designed to encourage insurers to maintain and expand their Medicare HMOs, which are intended to have a much larger role under the new Medicare law.

Step Toward Privatization?

Those opposed to the new Medicare law have said the government is providing free-market incentives to lure seniors into managed care plans as part of an effort to undermine traditional Medicare.

Representative Pete Stark of California, the senior Democrat on the House Ways and Means Subcommittee on Health, said the reimbursement rate increases are "a first step in the march toward privatization" of the Medicare program. "Medicare HMOs," he claimed, "were already substantially overpaid relative to what it would cost to serve the same beneficiaries in Medicare, even before this significant rate increase."

But Medicare HMO insurers and consumers disagreed, saying the higher payments were necessary because reimbursements were falling behind the actual costs of providing adequate health care.

According to Robert Goldberg, director of the Manhattan Institute's Center for Medical Progress, "Democrats like to point out that Medicare spends less on the same services than private health plans. But private health plans have offered richer benefits and newer technologies more quickly than Medicare in a more coordinated form. So, seniors are more likely to get better access to comprehensive care at a lower total cost."

During debates prior to the reform bill's passage, Charles Rangel, the Democratic Representative from New York, had warned "this bill will not reform the Medicare system as we know it but rather dissolve it." California Republican Bill Thomas essentially agreed, saying, "We certainly hope so." AAHP responded as well, saying the higher government payments are a step toward stabilizing managed care plans under Medicare, not "dissolving it."

Between 1999 and 2003, health plans dropped more than 2.4 million Medicare beneficiaries. Some insurers pulled out of Medicare entirely, while others curtailed their participation by withdrawing from specific counties.

Leslie V. Norwalk, acting deputy administrator of the federal Centers for Medicare & Medicaid Services, predicted the increased payments, which took effect March 1, will encourage many private plans to return to the Medicare HMO program.

About 4.6 million beneficiaries—11 percent of the 41 million people enrolled in Medicare—are in HMOs, which have customarily provided drug benefits and preventive care not available in the original Medicare program. Enrollment peaked in late 1999 at 6.3 million, or 16 percent of all beneficiaries.

The Bush administration predicted the new Medicare law will encourage people to enroll in HMOs and similar private plans called preferred provider organizations (PPOs). Administration officials estimate that by 2007, 35 percent of Medicare beneficiaries will be members of such plans.

Tommy G. Thompson, secretary of the Department of Health and Human Services, described the increased payments as "an investment in our seniors." As a result of the reimbursement increase, Thompson said, Medicare beneficiaries will have more consumer choice and better medical services.

"The *Pittsburgh Post-Gazette* reported the Pennsylvania insurer, Highmark. is slashing premiums by as much as 64 percent. ... [M]onthly premiums for Medicare HMO beneficiaries in the Security Blue Basic plan will drop from $56 a month to $20 a month ..."

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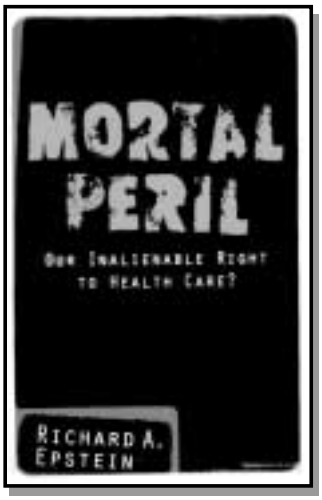

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Patients Caught in Crossfire as Bureaucrats Take Aim at Doctors

by Robert J. Cihak, MD

In the 1930s, Joseph Stalin noted the Soviet population wasn't growing fast enough to build his workers' paradise quickly enough. So he shot the census takers. The next batch of census takers weren't any better.

But the third generation of census takers reported enough population growth to keep Stalin happy—and keep their own lives in the process.

This last batch of census takers "got the message." As Solzhenitsyn reported in *The Gulag Archipelago*, doctored statistics in the Soviet Union weren't simply a matter of bureaucratic empire-building; a census taker's life literally depended on keeping the dictator happy.

This anecdote from history exhibits a double idiocy. What did Stalin know about taking a census? And how would shooting the census takers cause population growth ... unless it is presumed they were incompetent slackers who would do their job only under threat of dire punishment?

Increasingly, the story of the Soviet census-takers describes the relationship between America's doctors and America's government. The irony is that the medical system here was working pretty well until the government resorted to its "shoot the doctors" approach to medicine.

Two Ongoing Examples

The first example pertains to the threats faced by doctors prescribing pain-controlling medication to their patients. Federal government officials have taken a "guilty until proven innocent" attitude toward doctors who prescribe pain medication they believe appropriate to address serious and long-lasting pain.

Some doctors have been literally "under the gun." Government agents broke down the doors of Dr. Jonathan Wright's office in Washington state, seeking to investigate the heinous crime of using a form of Vitamin B12 that didn't meet the government's idea of what a "good vitamin" should be.

In March 2003, federal agents stormed the office of Dr. Jeri Hassman, a Tucson pain specialist, put her in handcuffs, and took her to jail. Drug Enforcement Agency (DEA) agents had noticed she was prescribing unusual quantities of morphine-based drugs and concluded Hassman was "prescribing controlled drugs outside the normal practice of medicine." They charged her with 362 counts of that crime.

In January, Hassman entered a guilty plea to four counts, thus avoiding the possibility of nearly 30 years in prison. She faces six months in jail and five years' probation.

If Hassman is indeed a criminal—362 counts is a lot—why did she get off so easily? Or did the feds just load her down with so many counts she couldn't afford to fight? The message seems clear: "Beware, physicians of America! This could happen to you if we don't like your prescription-writing."

Scores of doctors have faced such intimidation. Some have been imprisoned. One has committed suicide. Many have lost their medical licenses, run up ruinous legal bills, and gone bankrupt.

The lessons have not been lost on honest doctors, many of whom grow ever more reluctant to prescribe serious pain medication to their patients who need it most.

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Medicare, Not

A second area where the government has been busily threatening to "shoot first, ask questions later" involves Medicare. By law, doctors may treat Medicare patients only in accordance with what the government sanctions.

Moreover, a doctor may not treat any Medicare-eligible patient privately outside the Medicare system if the doctor accepts a penny of Medicare money.

As a result, more and more doctors are refusing to treat Medicare patients at all. They're simply fed up with the limits on their ability to treat patients appropriately, the paperwork, and the constant threat of legal action, including prison, if they deviate at all, even inadvertently, from the 130,000 pages of Medicare law (plus Official Government Regulations, plus contracted Insurance Carrier Policies). It's a regulatory labyrinth so complex not even the enforcers understand it.

I know personally many doctors who have "opted out" of the Medicare system. They are very happy with their decision to go back to the old system of offering competent care at reasonable cost.

Where from Here

So, what should patients caught in the crossfire do?

First, if you're covered by Medicare or any government health care program, be aware that your doctor is working under constant threat of fine and/or imprisonment.

Second, if you're a pain patient, ask your doctor upfront whether you're getting the medication you need. If you're not, ask what you can do to help make that happen.

And third, if you're a Medicare patient looking for a doctor whose top priority is to take care of you instead of pleasing the Medicare bureaucracy, find a doctor who has opted out of government-run health care.

After all, you wouldn't shoot a census taker just because the numbers didn't suit you. Would you?

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